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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on 11/03/08 through 11/05/08. The census was 47 residents. The sample size was 13 residents. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000		
F 164 SS=B	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview it was determined that the facility failed to maintain confidentiality of personal health information for all residents.

Findings include:

On 11/4/08 at 2:00 PM, the survey results binder was observed on the wall outside the social workers office door. Review of the book revealed documents that were not related to surveys. The documents listed each resident in the facility and their conditions including incontinence, cognitive impairment, infections, use of psychoactive medications, depression, and behavioral problems.

On 11/4/08 at 2:15 PM, the Director of Nurses was interviewed and reported that the personal health information and resident names should not be in the survey results binder. He reported that he had not been aware that it was in the binder.

On 11/4/08 at 3:00 PM the Unit Coordinator was interviewed and reported that she had never seen any one review the survey results binder. She was aware that family members touring the facility

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F 164	Continued From page 2 had been encouraged to review the recent survey results.	F 164		
F 223 SS=G	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure residents, specifically Resident #13, were free of mental anguish from the abusive verbal outbursts and behaviors of one resident (#13) residing in the facility. Findings include: Resident #11 was admitted to the facility on 8/6/08 with diagnoses including, chronic renal failure with hypertension, decubitus ulcer, cerebral vascular accident, congestive heart failure, sepsis, diabetes mellitus type 2, gastroesophageal reflux disease, anxiety and anticoagulant therapy. Resident #13 was admitted to the facility on 5/6/08 with diagnoses including hypothyroidism, hypokalemia, urinary tract infection, osteoporosis, vascular dementia, anxiety, and abdominal pain. Record review revealed that Resident #13 and Resident #11 had been roommates and that Resident had severe behavioral problems	F 223		

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including verbal abuse of residents with any disability or cognitive deficits. Record review revealed that Resident #11 was moved to another room to ensure Resident #13's safety.

Resident #13 was interviewed on 11/5/08 at 3:15 PM, and reported that she was "afraid of a woman and that she will be scared until that mean lady is gone." She referred to Resident #11.

On 11/5/08 record review revealed that Resident #11 had numerous behavioral issues with verbal abuse to staff and residents, self harm, refusal of treatments and medications, refusal of dietary restrictions and self-isolation episodes. Review of the "Behavior Charting" document showed the following:

9/11/08-Yelling with profanity at staff and residents in main dining room.
9/12/08-Yelling and profanity in hallway, refused dressing change.
9/15/08-Non-compliance with dietary orders, yelling profanities at nurses at nurses station.
9/18/08-Paranoid thoughts, states "she was in hell and needed to kill herself, nothing is real"
9/21/08-In hallway told a CNA "just wanted some drugs so she could die."
9/22/08-Anxiety attack and sent to emergency room
9/26/08-Combative with care. Refused to change soiled (urine and feces) clothes.
9/30/08-Noncompliant with diet restrictions became verbally abusive to staff.
10/1/08-Refused medications, dressing change and care needs.
10/4/08-Combative with care, noncompliant with diet restrictions.

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10/14/08-Verbally abusive with staff, refusing care and medications.

10/18/08-Verbally abusive with profanity in halls.

10/25/08-Defecated into her hands and threw it at staff, walked in feces around her room.

10/28/08-Cut herself with a razor, refused to give up the razor, shouting profanities.

Review of the record revealed that nursing staff was not reporting all behaviors to the Director of Nursing (DON), or the physician. Care plans were not updated and actions to provide and maintain resident and staff safety were not addressed. Review of the nurses notes dated 9/29/08 revealed documentation that staff refused to provide care at times when Resident #11's behaviors were escalating; "I left her room, she turned on her call light multiple times for me to return and I refused."

Random observations were made of the Resident #11's room from 11/4/08 at 9:00 AM until 11/5/08 at 4:00 PM. Resident #11's door was closed most of the time. When the resident turned on her call light it was answered in a timely fashion by staff. The resident was observed once in the morning on 11/5/08 in the morning out at the nurses station for about five minutes and then returned to her room with the door shut.

An interview was conducted on 11/5/08 at 8:30 AM, with the Director of Patient Care Services LTC (Director) and the Social Worker and reported that Resident #11 was very intolerant of people with cognitive deficits and involuntary movements. They revealed that Resident #11 had been verbally abusive to residents numerous times in the past. The Director reported that

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Resident #11 was not appropriate for the facility setting, Both employees stated they "felt their hands were tied in regard to getting Resident #11 transferred to a more appropriate facility." The resident's physician felt Resident #13 was competent to make her own decisions even if that included refusal of any care and the staff did not thoroughly convey the severity of the residents outbursts and threats of harm to the physician. The Director and the Social Worker revealed that no interventions such as 1 to 1 observation or 15 minute checks had been initiated to maintain the safety of Resident #11 or others. The Social Worker and Director reported that the facility staff have tried to pacify her to keep her calm.

On 11/5/08, at 10:06 AM, a Certified Nursing Assistant (CNA) was interviewed and reported that Resident #11 is "very mean and says very mean things to staff and residents." The CNA further reported that she is afraid to enter Resident #11's room and is afraid of what she may find in the resident's room.

An interview was conducted with Resident #11 on 11/5/08 at 10:45 AM in her room. She stated that she stayed in her room most of the time, but when she wants she can go out. She stated she has "suffered from anxiety for over 30 years and that boredom can trigger her anxiety attacks." She reported that she is "able to get out and has easy access to other patients." She reported that she frequently goes outside to the "Veranda" with other resident's. When asked if she is supervised on the "Veranda", she stated "sometimes." She was cooperative and talkative and did not make reference or mention of poor behaviors.

Review of a document titled "Comments" written

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by the Activities Director revealed "Resident #11's behaviors this morning during activities were beyond appropriate and very insulting and hurtful to those around her. She threw a beach ball at my face and then again towards residents seated near her. She was verbally abusive to everyone (7 residents, 1 staff) in the activity room repeatedly."

An interview was conducted on 11/5/08 at 2:00 PM, with the Activities Director. She recalled an incident with Resident #11 on 9/3/08 during an activity; several residents were involved. Resident #11 was escorted back to her room because her behavior was inappropriate and "I felt it was a safety issue for everyone." The Activities Director reported that she recommended to nursing that Resident #11 be moved to another room to protect Resident #13. She reported that she had no evidence to support that Resident #11 had ever been abusive to Resident #13. Because Resident #11 had been so verbally abusive to residents with cognitive deficits in the past, she was concerned that Resident #11 may have been verbally abusive to her (Resident #13).

A conference was conducted with all the surveyors, the Administrator, DON, Director, and the Risk Manager on 11/5/08 at 12:15 PM, to discuss Resident #11's behaviors and care. The Administrator, DON, and Risk Manager stated they were not aware of the severity of Resident #11's behaviors. The Director confirmed that she did not make them aware and that the State Agency was not notified as well.

Cross Reference Tag F 225 Staff Treatment of Residents

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225		

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by:
Based on record review, policy review and interview, the facility failed to ensure that allegations of sexual abuse and verbal abuse were reported inaccordance with the facility's policy in order to conduct investigations and to determine correction action for two events.

Findings include:

Review of the facility's Abuse Prevention Policy and Procedure revealed that "Any alleged, suspected, or observed behaviors by staff or visitors that could be indicative of prohibited behaviors will be immediately reported as outlined within this policy or as required by law. Any unusual injuries or injuries with unknown cause will be reported as outlined below." The policy directed staff that any alleged, suspected or observed abuse, neglect, mistreatment or exploitation would be reported immediately and an investigation would begin. This policy has been in effect since October 1999, and revised August 2007 and January 2008.

Resident #4 was admitted the facility on 8/25/08. She resided in a room with another female resident. Review of the clinical record revealed documentation by Social Services that, on 8/29/08, a certified nursing assistant (CNA) reported to social services that Resident #4's husband was fondling her female roommate. The CNA intervened and Resident #4 stated "he had Alzheimer's and doesn't know what he is doing." The documentation indicated that the husband was removed from the room. Social services called the residential home where the spouse lived and informed them that Resident #4's husband could not be left alone during visits; a

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chaparone was requested. The other option was that all visits by the husband to Resident #4 be confined to public areas of the facility. The documentation did not include the time of the event, the CNA's name who reported the event or the resident who was fondled.

An interview with the Director of Patient Care Services LTC (Director) was conducted at 11:00 AM on 11/4/08. She stated she was aware of some sort of event, but thought that a CNA intervened before there was any actions. The Director confirmed that no incident report was made out, no investigation was conducted, and that Risk Management was not aware of the event.

An interview with the Social Worker at 1:00 PM on 11/04/08, confirmed she was the author of the note. She stated the CNA came to her and reported she saw the husband of Resident #4 touching the female roommate inappropriately and the CNA intervened. The social worker confirmed she immediately interviewed the female roommate who confirmed Resident #4's husband had touched her on her top, indicating her chest area. The social worker stated she did not feel Resident #4's husband had any sexual intentions as he was beginning to show signs of dementia.

The social worker confirmed she did report the event to the nursing staff at the nurses station, telling them that Resident #4's husband had touched the roommate inappropriately. The social worker confirmed she did not make out an incident report or inform the facility administration. She stated the residential home was not compliant in making sure someone could stay

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with the husband during his visits, so visits were conducted in the public areas. She also confirmed she could not recall the CNA who reported this. She was not aware if the nursing staff filled out an incident report.

An interview with the Education Coordinator on 11/5/08, confirmed all staff were educated regarding the abuse and neglect policies during orientation, and then yearly.
Resident #11 was admitted to the facility on 8/6/08 with diagnoses including, chronic renal failure with hypertension, decubitus ulcer, cerebral vascular accident, congestive heart failure, sepsis, diabetes mellitus type 2, gastroesophageal reflux disease, anxiety and anticoagulant therapy.

Resident #13 was admitted to the facility on 5/6/08 with diagnoses including hypothyroidism, hypokalemia, urinary tract infection, osteoporosis, vascular dementia, anxiety, and abdominal pain.

Record review revealed that Resident #13 and Resident #11 had been roommates and that Resident had severe behavioral problems including verbal abuse of residents with any disability or cognitive deficits.

Review of a document titled "Comments" written by the Activities Director revealed "Resident #11's behaviors this morning during activities were beyond appropriate and very insulting and hurtful to those around her. She threw a beach ball at my face and then again towards residents seated near her. She was verbally abusive to everyone (7 residents, 1 staff) in the activity room repeatedly."

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F 225	Continued From page 11 An interview was conducted on 11/5/08 at 2:00 PM, with the Activities Director. She recalled an incident with Resident #11 on 9/3/08 during an activity; several residents were involved. Resident #11 was escorted back to her room because her behavior was inappropriate and "I felt it was a safety issue for everyone." The Activities Director reported that she recommended to nursing that Resident #11 be moved to another room to protect Resident #13. She reported that she had no evidence to support that Resident #11 had ever been abusive to Resident #13. Because Resident #11 had been so verbally abusive to residents with cognitive deficits in the past, she was concerned that Resident #11 may have been verbally abusive to her (Resident #13). A conference was conducted with all the surveyors, the Administrator, DON, Director, and the Risk Manager on 11/5/08 at 12:15 PM, to discuss Resident #11's behaviors and care. The Administrator, DON, and Risk Manager stated they were not aware of the severity of Resident #11's behaviors. The Director confirmed that she did not make them aware and that the State Agency was not notified as well. Cross Reference Tag F 223	F 225		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		

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nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on record review, policy review and interview the facility failed to document interventions in order to prevent weight loss for 1 of 13 residents. (#1)

Findings include:

Resident #1 was admitted on 7/28/08, with diagnoses including congestive heart failure, blepharitis, status post pacemaker placement with chronic methicillin resistant staphylococcus aureus (MRSA) infection at placement site, and chronic obstructive pulmonary disease.

The review of resident #1's record revealed that she was 5 foot 6 inches tall and weighed 92 pounds or 86% of her ideal body weight (IBW) at the time of her admission on 7/28/08. Record review revealed that on 10/30/08, the resident weighed 86.6 pounds or 72% of her IBW. The 5.4 pound weight loss equaled 5.8 percent in three months. The dietician had documented on 7/28/08, that the resident was extremely underweight with inadequate nutritional intake with potential malnutrition. A document titled "Nutritional Assessment" was blank.

Record review revealed the dietician recommended that the resident be offered Healthshakes as needed on 8/7/08. The record failed to have documented evidence that the recommendation was ordered or declined by the

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physician. On 9/4/08, the documentation revealed that the dietician had recommended warming the Healthshakes. No evidence was found that the Healthshakes were ordered at that time and no evidence was found that the staff offered Healthshakes.

Review of the "Medical Nutritional Therapy Assessment Recommendations" for 7/10/08, revealed no entries made related to Resident #1. Review of the recommendations for Resident #1 made on 8/7/08, read: "continued weight loss down 36 pounds." No recommendations were found for 9/08 or 10/08.

Record review revealed a care plan titled "Risk for Inadequate Nutrition." Offering Healthshakes nor warming Healthshakes was not listed as an approach for Resident #1.

A registered nurse was interviewed 11/4/08 at 3:10 PM. The nurse reported that she had no knowledge of the dietician's recommendations. The dietician typically left a copy of her written recommendations on a document titled "Medical Nutritional Therapy Assessment Recommendations" in her mailbox for review and implementation. The nurse reported that the dietician was made aware of the Resident #1's continued weight loss, that the dietician had been reviewing all weights weekly, and was aware of the resident's ongoing decline.

Review of the resident's meal intake percentage revealed that the residents meal intake was not consistently documented. Review of the meal intake percentages revealed that the resident's meal percentages were documented on 55 of 71 days. Of the 55 days

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	295011	A. BUILDING _____ B. WING _____	11/05/2008

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SOUTH LYON MEDICAL CENTER	P.O. BOX 940 YERINGTON, NV 89447

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F 325	Continued From page 14 documented the resident was documented as refusing 32 meals during her admission to the facility. Record review revealed that nursing requested an order for protein powder added to her hot chocolate on 10/31/08. No evidence was found that the Dietician was aware of the order. Evidence was found that the resident was receiving and accepting the hot chocolate with protein powder as ordered and continued to have weight loss. On 11/4/08 at 10:40 AM, the Dietician was interviewed. She reported that it was her responsibility to complete the nutritional assessment, but that nursing would have to leave a request for consultation in her mail folder or she would not assess that resident. She reported that she did not follow-up on residents unless nursing requested her to do so. She reported that she does not follow-up to ensure that recommendations are implemented. She reported that she did not review the Resident #1's record between 9/4/08 and 10/30/08, because nursing did not request that she do so.	F 325		
F 361 SS=D	Cross reference Tag 361 Dietary Service-Staffing 483.35(a) DIETARY SERVICES - STAFFING The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based	F 361		

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F 361	Continued From page 15	F 361		

upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.

This REQUIREMENT is not met as evidenced by:
Based on record review, policy review and interview, the facility failed to ensure that the dietician followed the facility's policy related to the assessment of residents for nutritional risk and failed to ensure that the dietician participated in the interdisciplinary care planning meetings for all residents at risk for weight loss.

Findings include:

The facility's nutritional risk assessment policy indicated that the consultant dietitian was to review submitted nutritional risk assessment forms completed by the nursing staff and recommend any nutritional interventions within 48 hours of submission. A review of resident files and an interview with a registered nurse revealed that recommendations by the dietitian were made twice a month, when the dietitian was present in the facility.

On 11/4/08, at 10:40 AM, the dietician was interviewed and reported that is her responsibility to complete the nutritional assessment but that nursing would have to leave a request for consultation in her mail folder, or she would not assess that resident. She reported that she does not follow up on residents unless nursing requested her to do so. She reported that her

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F 361	Continued From page 16 role is to make recommendations on a consultant basis only. She reported that she does not attend any care conferences or confer with any other discipline except nursing. She reported that she does not follow up to ensure that recommendations are implemented. She reported that she did not review the resident's record between 9/4/08, and 10/30/08, because nursing did not request that she do so. Policy review revealed a policy titled "Nutrition Care Planning." The policy read, "It is the policy of South Lyon Medical Center that a care plan for nutrition therapy is developed in a multidisciplinary format and implemented for all patients determined to be at nutritional risk. The procedure was as follows: -Based on the results of the nutritional screening and assessment, the clinical dietitian or Nutritional Services Supervisor will formulate a plan for nutrition therapy in collaboration with other disciplines as appropriate. All patients assessed as having high nutritional risk will have a care plan. -The objective is to provide optimal nutritional care compatible with medical treatment through planning and implementation and monitoring/evaluating. -The plan for nutrition therapy is revised at the time of reassessment and follow up according to the patients condition and progress. Cross reference Tag F 325 Nutrition	F 361		
F 371 SS=B	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		

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F 371	Continued From page 17 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure that food was stored, prepared, distributed and served under sanitary conditions. Findings include: During an inspection of the facility's kitchen on 11/5/08, the following observations were made: Storage of food: opened bags and boxes of food items were undated; an opened bag of chocolate chips was dated 12/3/07; a box of 2.2 oz packets of Crystal Light was dated 8/2/07; fifteen boxes of diabetic dessert packages were dated 11/19/06; a #10 can (106 oz) of tomato juice was dented Refrigerators: an opened container of sour cream was not dated. The Risk Manager revealed that the facility's policy was to date all opened food items and discard them after four days. Freezers: a box of chicken cordon bleu (no longer used on the menu) was dated 7/5/08. An opened bag of mini corn dogs was undated. Preparation of food: a check of the food temperatures during the lunch tray line at 11:30 revealed that the teriyaki chicken was 130	F 371		

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F 371	Continued From page 18 degrees at the front of the tray. It was observed that the tray line was situated next to the hood ventilation fan. The Kitchen Supervisor stated that the fan cooled food items quickly. Service of food: a kitchen employee was observed failing to change her gloves after using a wet dish rag to wipe a counter and before serving lunch items onto plates. Sanitizers: a pH test of the chlorine-based sanitizing solution in a wash bucket indicated the concentration of the solution at 200 ppm was higher than the recommended concentration of 100 ppm. The Kitchen Supervisor stated that the kitchen staff did not have a method of accurately measuring the amount of sanitizer to be used in the bucket.	F 371		